

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011506</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/11/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5165 MCCARTY LN LAFAYETTE, IN 47905</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00150133 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 011506</p> <p>Survey Date: 02/11/2015</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Indiana University Health Arnett Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/11/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE